

REPRODUCTIVE Quarterly

NEWSLETTER OF THE REPRODUCTIVE HEALTH PROGRAM
UTAH DEPARTMENT OF HEALTH

INSIDE INFORMATION

- Anna's Surfing Secrets
- Public Charge Defined
- Postpartum Depression – Beyond the Blues
- Utah SIDS and Other Infant Deaths
- Sex Education in the Utah Public Schools
- Myth vs. Fact

ANNA'S SURFING SECRETS

... *Don't worry. You can't break the internet.* ...

Anna West, C.H.E.S.

What's so great about the internet?

The internet is like a gigantic library you can access without leaving your desk. Like a library, though, you have to learn how to get there and then find what you need! In this edition of Anna's Surfing Secrets, you will learn about getting started on the internet, on-line tutorials, and how to find information on the web.

How do I get started?

Get a computer expert to help you get started on-line. You will need a computer, a browser program, and a way of connecting to the internet. A browser is the software that allows you to surf the internet, like Netscape or Internet Explorer.

Next, you need to learn how to use the browser. A free on-line tutorial is the best way to get started. The Utah Department of Health (UDOH) offers a free tutorial for public health professionals in Utah. Paul Wightman, UDOH's webmaster, is the instructor for the course. To find out more about this free tutorial, go to the Internet Navigator Course at <http://www.lib.utah.edu/navigator/>. Other internet courses can be found through search engines.

How do I find stuff?

There are 3 main ways to find information.

1. Search Engines – Type keywords into a search engine, like Excite, Infoseek, or Alta Vista, and you will get a list of websites that include those keywords. Then click on the sites that look most promising. You can get to search engines by clicking on the search button located at the top of your browser, or by typing in an address, like www.excite.com
2. Internet Guides – There are many websites that act like yellow pages, called internet guides. They keep a list of websites organized by topic. Go to one of these sites, click on the topic you are interested in, and then select from a list of sites. These sites often also have a search engine. Examples include:
 - www.yahoo.com
 - www.hotbot.com

3. Finally, you can get to a website by typing in an address that you already know. Try this one: www.utahrhp.org

Watch the next edition of *Reproductive Quarterly* for more of Anna's Surfing Secrets!

(Anna West is the Sudden Infant Death Program Coordinator with the Utah Department of Health. For further information, she can be reached at 801-538-9970, FAX 801-538-9409, or e-mail awest@doh.state.ut.us.)

PUBLIC CHARGE DEFINED!

For providers working with aliens (undocumented persons) one of the most confusing issues has been whether or not aliens may receive certain federal and/or state programs without endangering their immigration status on the basis of becoming a "public charge." In the May 26, 1999 *Federal Register*, the Department of Justice (DOJ) published standards defining what constitutes becoming a "public charge." DOJ defines public charge to mean, "...an alien who has become ... or is likely to become ... primarily dependent on the government for subsistence, as demonstrated by either the receipt of public cash assistance for income maintenance or institutionalization for long-term care at government expense."¹ The following benefits, among others, are **NOT** subject to public charge consideration - Medicaid, Children's Health Insurance Program (CHIP), WIC, immunizations, prenatal care, treatment of communicable diseases, and emergency medical assistance. Therefore, aliens using the Baby Your Baby (Prenatal Presumptive Eligibility), WIC, CHIP, or Medicaid Programs - including Emergency Medical Assistance - cannot be denied citizenship as a result of receipt of those services. Of course, a non-citizen applying for these programs must still meet each program's eligibility standards. Please relate this new ruling to alien clients applying for the above programs. If you have questions, please contact Debby Carapezza at 801-538-9946. Additional information is on the Health Resources and Services Administration (HRSA) website at: <http://www.hrsa.gov>. - ed.

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POSTPARTUM DEPRESSION – BEYOND THE BLUES

Debby Carapezza, C.F.N.P.

Most health care professionals involved in the care of postpartum women are familiar with the “baby blues” experienced by many new mothers. But what happens if those so-called “blues” never seem to go away or become so severe that the new mother finds it difficult to cope with the activities of daily life?

Each year in the United States, 15% to 20% of adults experience a major depression. The incidence of depression among women is twice that of men and peaks between 18 to 44 years of age – the childbearing years of a woman’s life. Women are at increased risk of mood disorders during periods of hormonal fluctuation i.e., premenstrual, postpartum, or perimenopausal periods in their lives.¹ Mood disorders in the postpartum period can range from mild to severe. Within the first two weeks following delivery, 50% to 80% of women experience transient “baby blues”. At the other end of the spectrum is postpartum psychosis, a medical emergency, that is experienced by only 0.1% to 0.2% of women, usually within the first 4 weeks following delivery. Whether or not these postpartum mood disorders constitute a distinct category of psychiatric disturbances continues to be debated.²

Midrange in the above spectrum of postpartum mood disorders is postpartum depression (PPD), also known as postpartum major depression (PMD). Depending on the diagnostic criteria used, the percentage of postpartum women affected by this disorder ranges from 6.8% to 16.5%.² The onset of symptoms may begin as early as 24 hours or as late as several months following delivery.^{1,2} Symptoms of PMD may include feelings of hopelessness, helplessness, persistent sadness, irritability, low self-esteem, sleep or appetite disturbances, inability to concentrate, and loss of pleasure in activities.³ Additionally, women with PMD may complain of mood changes and inability to adjust to their roles as mothers. However, symptoms can range from mild dysphoria to suicidal ideation or psychotic depression. Untreated, PMD symptoms can last from several months or into the second year postpartum.²

Theories regarding the etiology of PMD range from hormonal changes of the puerperium to psychosocial factors. Numerous studies have attempted to pinpoint various postpartum hormonal excesses or deficiencies including increased or decreased levels of prolactin, progesterone, thyroxine and tryptophan, among others, as the source of PMD.^{2, 4, 5} Other theories regarding the etiology of PMD cite numerous psychosocial factors associated with the illness including marital conflict, child-care difficulties (feeding, sleep, and health problems), and the perception by the mother of an infant with a difficult temperament. Other studies have pointed to the role of a positive family history of depression or personal history of depression among PMD sufferers.

Health care personnel working with postpartum women need to be aware of factors that may place a woman at increased risk for the development of PMD. These include: a family history of mood disorder, client history of a mood disorder prior to

pregnancy, anxiety/ depression during pregnancy, postpartum depression with previous deliveries, or baby blues following current delivery, child-care difficulties (see above list), marital conflict, stressful life events, and poor social support.²

Failure to identify and treat postpartum depression can have long term consequences for the mother, the infant and the entire family. Yet women with postpartum depression may be hesitant to mention the problem to their health care providers. Some may not recognize they are depressed and believe their feelings are “normal” for new mothers. Others feel they might be considered “bad” mothers if they admit that their experience with motherhood is less than the societal picture of bliss. Still others may feel they are “going crazy” and fear that their babies might be taken from them. PMD can undermine a woman’s confidence in her ability to successfully parent her child.¹ Various studies of infants of mothers with PMD have revealed negative impacts on the babies’ social, emotional and cognitive development. One such study found that when compared with infants of non-depressed mothers, 2-month-old infants of women with PMD showed decreased cognitive ability and expressed more negative emotions during testing. When compared with babies of non-depressed mothers, babies of mothers with PMD were perceived by their mothers as more difficult to care for and more bothersome. This perception and the infant’s response to it may serve to increase the woman’s depressed mood and her sense of failure as a mother.⁶

Treatment is available for PMD but cannot be instituted until the illness is recognized. Women must be educated regarding PMD during their childbirth education classes and by their health care providers. Discussing a client’s feelings with her not only causes her to stop and perform her own mental self-evaluation, but also indicates the provider’s concern for her wellbeing and willingness to assist her.¹ Women with a history of PMD, mood disorders or with family histories of mood disorders or with other risk factors should be counseled regarding the increased potential of developing PMD following delivery. Treatment modalities can then be discussed and psychosocial support established prior to delivery. Additionally, all postpartum women should be screened for PMD at their postpartum examination. Screening can be done by one of several tools. One commonly used tool is the self-administered Edinburgh Postnatal Depression Scale (EPDS) consisting of 10 statements dealing with how the mother has been feeling over the past week. In addition to self-administered screening tests, clinical assessment must also be carried out to confirm the diagnosis of PMD.⁷

Once diagnosed, several treatment options are available for postpartum mothers. The first focus of treatment is to educate the woman and her support system regarding PMD.² Treatment for PMD is based on therapies developed for non-puerperal depression. Due to limited information on the use of antidepressants while breastfeeding, some women may prefer nonpharmacologic interventions. These clients, as well as those on antidepressants, may benefit from either individual or group therapy and if marital conflict is involved, couples should be referred for appropriate counseling. Support groups for women suffering from PMD are available and all clients should be made

aware of these resources (see textbox at end of article for resources).¹

The use of tricyclic antidepressants and Paxil, Prozac, and Zoloft, selective serotonin reuptake inhibitors (SSRIs), may be indicated for both nursing and non-nursing women. The recommendation of specific agents varies among studies.^{1, 2, 8, 9, 10} Data thus far support the low incidence of infant toxicity and adverse effects associated with antidepressant and benzodiazepine use during breastfeeding. Decisions regarding nursing and the use of psychotropic medications should be made on a case-by-case basis. The provider must be familiar with the various agents and the hepatic function of both the mother and infant. The woman should be counseled regarding the risks versus benefits of pharmacological treatment for both herself and her infant including the unknown impact of long-term use of these medications on the neurodevelopment of the infant. However, the woman must also be made aware of the consequences of untreated depression for herself and upon her infant's development. If the woman chooses to continue breastfeeding while on medication, she should work collaboratively with a psychiatrist and her pediatrician. The infant's serum should be assayed for the presence of medication if insomnia or other changes in behavior are noted.¹¹ All discussions regarding pharmacological treatment while nursing should be thoroughly documented in the client's chart.¹⁰ Any severely depressed woman, those with suicidal or infanticidal ideation or not responding to antidepressant treatment should be referred to a psychiatrist for evaluation. Any woman with symptoms of psychosis should be referred for emergency psychiatric evaluation.¹

PMD is an easily overlooked but treatable problem. The consequences of untreated PMD are significant for the woman, her infant and family members. Maternal deaths have occurred in Utah as a result of suicide stemming from PMD.¹² All women should be educated regarding PMD and made aware of treatment and resources available to them. Providers need to be aware of risk factors for the development of PMD, screen all postpartum women for its presence, and appropriately treat and/or refer and carefully follow-up women affected by this disorder.

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RESOURCES FOR WOMEN AFFECTED BY POSTPARTUM DEPRESSION:

Depression after Delivery
Salt Lake County – No charge
Lynn Neff @(801) 268-1577

Counseling for Postpartum Depression at No Charge
LDS and Cottonwood Hospitals @(801) 269-2830

For additional resources, contact the Baby Your Baby Hotline at
1-800-826-9662

UTAH SIDS AND OTHER INFANT DEATHS

Anna West, C.H.E.S.

SIDS is diagnosed when the death of a baby remains unexplained even after autopsy, examination of the death scene, and review of medical records.¹ During 1997, 2,705 babies died of SIDS in the United States.² SIDS deaths have decreased by 38% since 1994 when a campaign began to encourage caregivers to place babies on their backs for sleep.³

In Utah during 1998, 34 Utah babies died while sleeping. In other words, during 1998, 0.8 babies out of every 1,000 babies died from SIDS, suffocation, or undetermined causes.⁴ A death may be declared due to undetermined causes if the Medical Examiner could not tell what caused the death. For example, it may be impossible to distinguish whether the baby suffocated or died of SIDS. If it appears as though the baby's airway was blocked, the Medical Examiner will declare suffocation as the cause of death. Suffocation deaths are only included in this analysis if the death occurred during sleep. Figure 1 shows that the rate of SIDS, suffocation, and undetermined deaths in 1998 is the lowest it has been since 1993.⁴

Figure 1 - SIDS, Suffocation, and Undetermined Death Rates, Utah, 1993-1998⁴

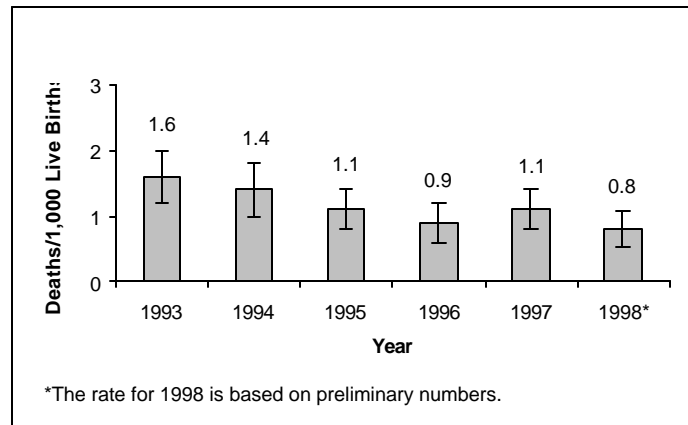
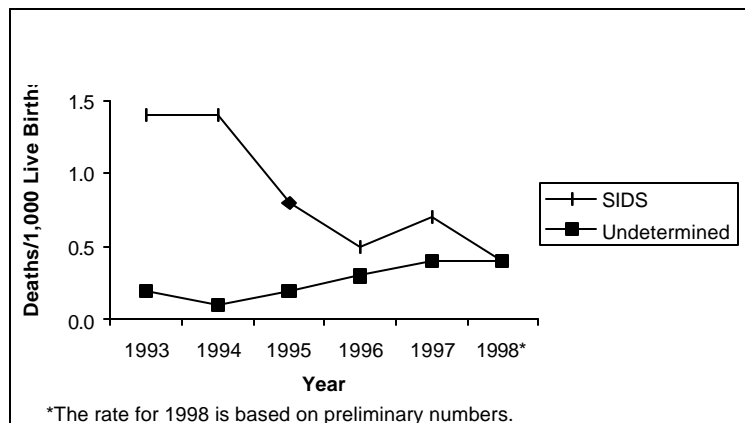


Figure 2 shows that the number of deaths due to SIDS is decreasing, while the number of deaths due to undetermined causes and suffocation – usually caused by an unsafe sleep environment – is increasing. In fact, in 1998 the rate of deaths due to an unsafe sleep environment was almost equal to the rate of SIDS deaths.⁴ Caregivers need to be educated about sleeping safety for babies to reduce the rate of these deaths.

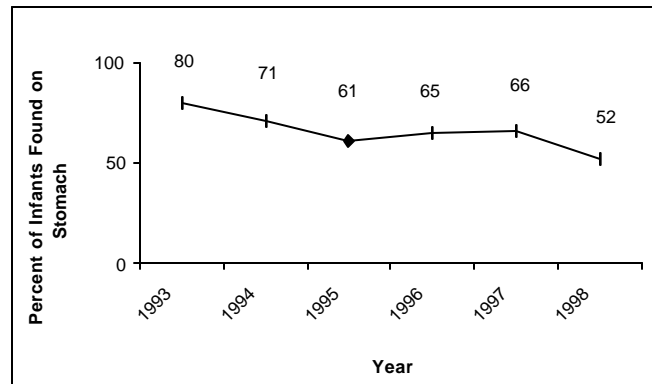
Figure 2 - Rate of SIDS and Infant Deaths Due to Undetermined Causes and Suffocation, Utah, 1993-1998⁴



Infants who sleep on their stomachs are at greater risk for SIDS.⁵ 1994 saw the beginning of the Back to Sleep Campaign, a program to educate caregivers that the back is the best sleep position for babies.³ Since this time, the percent of infants sleeping on their stomachs has decreased significantly.³ In Utah, while the SIDS rate is dropping, so is the percent of infants who are found dead on their stomachs. Even though this has decreased since 1993, in 1998 over half of infants who died of SIDS were found on their stomachs (see Figure 3).⁴ From this figure, it can be seen that back sleeping for infants is important to further decrease the rate of SIDS, undetermined, and suffocation deaths in Utah.

Figure 3 - Percent of SIDS, Suffocation, and Undetermined Deaths in Utah

Found On Stomach by Year



Before discussing SIDS risk factors, it is important to note that SIDS is not predictable or preventable. While SIDS risk factors can be identified from research, many SIDS fatalities have no risk factors, and SIDS is no one's fault. Babies are at greater risk for SIDS if they are male, 2 to 4 months of age, low birth weight, premature, or exposed to tobacco smoke during pregnancy, or after birth.^{5,6,7} Moms who give birth during their teen years or who get poor or no prenatal care are at greater risk to lose an infant to SIDS.⁸ Environmental risks for SIDS include stomach sleeping, soft bedding, an environment that is too warm, and sleeping in an unsafe place.^{9,10}

The Utah Department of Health SIDS Program tracks information, including risk factors, about all of the sleep related infant deaths in Utah. In the following table, several years of information about Utah's sleep related infant deaths is presented and compared with the general population of Utah births.

Risk Factor	Utah Births ¹¹	Utah Sleep Related Infant Deaths ⁴
Mom 15-19 years old	11%	18%
Mom achieved less than high school education	14%	29%
Unmarried mom	16%	37%
Late prenatal care	16%	30%
Low birth weight infant	6%	14%
Preterm infant	6%	14%
Exposed to tobacco smoke	9%	34%
Hispanic	8%	12%
Race	95% White	90% white

* Utah births uses data for years 1993-1997; Utah deaths uses data for years 1993-1998.

From this table, it can be seen that sleep related infant deaths in Utah were associated with teen and unmarried mothers, mothers who achieve less than high school education, were late entrants into prenatal care, had low birth weight and preterm births, were exposed to tobacco smoke, and were non-White or Hispanic.⁴ These risk factors are important for targeting further education about reducing the risk of SIDS and sleep related infant death.

<p>Sleeping Safety Tips:</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Don't let baby sleep on waterbeds, adult, youth beds <input checked="" type="checkbox"/> No soft stuff in baby's crib <input checked="" type="checkbox"/> Crib in good repair, mattress fits snugly <input checked="" type="checkbox"/> Crib bars close together, so a pop can is too big to fit between them 	<p>Tips to Reduce the Risk of SIDS:</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Get good prenatal and well baby care <input checked="" type="checkbox"/> Encourage breastfeeding <input checked="" type="checkbox"/> Don't smoke while pregnant, or allow anyone to smoke near baby <input checked="" type="checkbox"/> Place baby on his back for sleep, even for naps <input checked="" type="checkbox"/> One thin blanket in a room about 70 degrees will keep baby just the right temperature <p>Visit our website for more: www.utahrhp.org</p>
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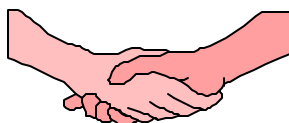
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THE SHARING CORNER



SEX EDUCATION IN THE UTAH PUBLIC SCHOOLS

Margaret Rose

As the school health education specialist for the Utah State Office of Education, I often hear many different "versions" of what can and can't be done in a classroom as it relates to sexuality education. It is common to receive comments like, "you can't say the 'c' word," "our district won't let us talk about contraception," "the teacher asked me to talk to students because she/he can't discuss the topic, but I can." My personal favorite is the request for the "list of words we can't say in a Utah classroom." Many of you have probably heard some of these same phrases, and others may have actually used them on occasion.

In an effort to clarify what can and can't be done in a public school classroom, it is important to first be aware of the following documents: Health Education Core Curriculum, Utah State Law, Utah State Board of Education rule, and any school district policies which may be in place.

Core curriculum in the state of Utah outlines the standards and objectives for what students will be taught in core classes, or those required for graduation. Within the Health Education curriculum are standards and objectives relating to healthy relationships, adolescent development, respect and responsibility, sexuality education, pregnancy and sexually transmitted infection prevention, HIV prevention, personal safety, and managing unhealthy relationships or situations. All presentations and

activities should help support the objectives within core curriculum.

Utah State Law requires schools to teach sexual abstinence, receive parental consent before discussing any aspect of contraceptive methods or devices with unmarried minors, and provide instruction on communicable diseases including AIDS. Once parental consent has been received, students may be present in the classroom for a factual discussion on contraception and/or condoms. If consent is not granted, then students are given an alternative assignment and do not attend class on the day of instruction. The focus of all curriculum and discussions in public schools presents abstinence as the very best option for young people. But that doesn't necessarily mean that we must teach abstinence at the exclusion of a more complete or comprehensive message.

Utah State Board of Education rules are created to help interpret statutes and offer clarification for schools and/or classroom teachers. State board rules relating to sexuality state that discussion about the "intricacies of intercourse, sexual stimulation, or erotic behavior" are not allowed. While teachers may not discuss specifics of sexual behavior, they may define sexual behavior or actions. State rules also prohibit teachers from advocating or encouraging the use of contraceptive methods or devices, therefore all discussions must be unbiased and factual. The same applies for discussions relating to homosexuality. Teachers may not advocate or teach acceptance of homosexuality, but may speak about it factually and without bias. And finally, teachers may not present promiscuity or sexual relations outside the context of marriage as acceptable. There are no words or topics that are completely off-limits for defining. Topics such as abortion, masturbation, and other sensitive issues are best handled if defined, and then followed by a suggestion that the student talk with a parent or guardian. Definitions of other sensitive issues may not necessarily be offered by a teacher, but may be discussed if a student asks a question. The answers or definitions must be concise, age

appropriate, and stay within the context and spirit of the laws and policies. Again, referral to a parent or guardian for more information is important.

Local school districts may enact rules similar to the state rules or policies. Districts may create policies that place more restrictions on what teachers may discuss or present in class, but they may not create policy that is more inclusive than what is in place in law or state policy. Currently, only Nebo School District has a written policy on file at the State Office of Education that states that teachers in Nebo District will teach only abstinence. This policy obviously precludes teachers from discussing contraception and/or the use of condoms.

As a guest in any public school or classroom in the state of Utah, it is important to be aware of the district policies and guidelines. Once a person agrees to address young people, he or she becomes an “agent of the teacher” and the teacher is ultimately responsible for whatever the guest says or does. Therefore, it is in the best interest of all involved if the teachers and guest speaker(s) have a good working relationship, are familiar with the presentations and curriculum, and have developed a level of trust. With this in mind, our students will all benefit from our shared expertise.

(Margaret Rose is a health education specialist with the Utah State Office of Education. For more information she may be contacted at 801-538-7864, FAX 801-538-7769, or e-mail mrrose@usoe.k12.ut.us.)

Information on the Utah State Office of Education and the Core Curriculum, including Health Education for grades 7 through 8 and 9 through 12, can be found on the web at: <http://www.usoe.k12.ut.us>

Information on Utah law and policy regarding sex education follows each section of the above sections

ANNOUNCEMENTS

In case you didn't notice, this issue of the *Reproductive Health Quarterly* is focused on SIDS. There is a reason for this! **October is SIDS Awareness Month!!** For more information on SIDS check out the Reproductive Health Program's website: www.utahrhp.org.

SAVE THIS DATE!!!

The 2000 National SIDS Alliance Conference will be held in Salt Lake City April 8th, 9th, and 10th. Pre-conference sessions will be held on the 7th. This will be a great opportunity to attend a national conference right in our own back yard!



??? MYTH

vs.

FACT !!!!

**Babies are not
at risk for
SIDS during
naps.**

**Babies are at risk
for SIDS during
any period of
sleep, even naps.**

Anna West, C.H.E.S.

A healthy baby should always sleep on his back, regardless of the time of day. In fact, 57% of Utah babies that died of SIDS between 1993 and 1998 died between the hours of 8:00 a.m. and 6:00 p.m.¹

A recent study found that babies might be at an increased risk for SIDS while at day care.² This may be because the baby was placed on her back to sleep at home, and then placed on her stomach for sleep while at day care. This increased risk for SIDS may occur because the baby is unaccustomed to the stomach sleeping position, and therefore less able to respond to stressors associated with this position than a baby who is used to sleeping on his stomach. Examples of these stressors include rebreathing (increased levels of carbon dioxide caused by a baby's face being trapped in soft bedding) and overheating. This finding highlights the need for the consistent use of the back sleeping position by all caregivers for babies during all periods of sleep, including naps. Grandparents, day care providers, and everyone who cares for infants must be made aware of the importance of back sleeping for infants.

The good news is that the Back to Sleep Campaign is working. The number of SIDS deaths per year has dropped by over 38% since the campaign began, resulting in almost 3,000 fewer infant deaths per year.^{3,4}

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